

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL090-195 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/07/2024 |
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| NAME OF PROVIDER OR SUPPLIER ANDERSON HEALTH SERVICES-SIMMONS | STREET ADDRESS, CITY, STATE, ZIP CODE 1915-C HASTY ROAD MARSHVILLE, NC 28103 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| V 000 | <p>INITIAL COMMENTS</p> <p>A follow up survey was attempted on 03/07/2024. According to the Quality Specialist there are no clients being served at the facility. The last time clients were served at the facility was 04/10/2023.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.</p> <p>This facility is licensed for 12 and currently has a census of 0.</p> <p>Interview on 03/07/2024 with the Quality Specialist revealed: -Clients were last served at the facility on 04/10/2023. -"We have plans to re-open the facility by 04/10/2024."</p> | V 000 | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____